Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

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Amended Public Report (A1)

Report Issue Date: February 15, 2023	
Inspection Number: 2022-1580-0002	
Inspection Type: Follow up Critical Incident System	
Licensee: City of Toronto	
Long Term Care Home and City: Seven Oaks, Scarborough	
Lead Inspector Sami Jarour (570)	**Inspector Digital Signature** Sami Jarour Digitally signed by Sami Jarour Date: 2023.02.21 11:06:48 -05'00'
Additional Inspector(s) Rita Lajoie (741754) Joanne Zahur (589) Deborah Nazareth (741745)	

AMENDMENT INSPECTION REPORT SUMMARY

This licensee inspection report has been amended due to software issues.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 28-30, December 1, 5, 6, 8, 9, 12-16, and 19-22, 2022.

The following intake(s) were inspected:

- Intake: #00002202, Intake: #00003157, Intake: #00003682, Intake: #00003747, Intake #00013679 related to incidents of alleged abuse.
- Intake: #00004498 related to a fall incident.
- Intake: #00011478 related to improper care and a fall incident.
- Intake: #00004419- CO#001 from inspection #2022_941746_0006, O. Reg. 79/10 s. 131. (2), CDD May 02, 2022
- Intake: #00006058- CO #001 from inspection #2022_1580_0001, FLTCA, 2021 s. 140 (2), CDD Sept 02, 2022

- Intake: #00005410- CO #007 from inspection #2022_1580_0001, FLTCA, 2021 s. 6 (4)(a), CDD Sept 02, 2022
- Intake: #00005844- CO #003 from inspection #2022_1580_0001, O. Reg. 246/22 s. 79 (1) 9, CDD Sept 02, 2022
- Intake: #00005845- CO #002 from inspection #2022_1580_0001, O. Reg. 246/22 s. 139 (1), CDD Sept 02, 2022
- Intake: #00006059- CO #009 from inspection #2022_1580_0001, O. Reg. 246/22 s. 41 (1)(a), CDD Sept 02, 2022
- Intake: #00006060- CO #005 from inspection #2022_1580_0001, LTCHA, 2007 s.24 (1), CDD Sept 02, 2022
- Intake: #00006061- CO #006 from inspection #2022_1580_0001, LTCHA, 2007 s. 23 (1)(a), CDD Sept 02, 2022
- Intake: #00006338- CO #008 from inspection #2022_1580_0001, O. Reg. 246/22 s. 102 (8), CDD Sept 02, 2022
- Intake: #00006339- CO #004 from inspection #2022_1580_0001, O. Reg. 246/22 s. 11 (1), CDD Sept 02, 2022

The following intakes were completed in the Critical Incident Systems inspection:
Intake: #00001473, Intake: #00002142, Intake: #00003520, Intake: #00003526, Intake: #00003661, Intake: #00004213, Intake: #00004218, Intake: #00004493, Intake: #00004838, Intake: #00005830, Intake: #00006056, Intake: #00007013, and Intake: #00007332 related to falls incidents.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2022_941746_0006, O. Reg. 79/10 s. 131. (2) inspected by Rita Lajoie (741754).
Order #001 from Inspection #2022-1580-0002 related to O.Reg. 246/22, s. 140 (2) inspected by Rita Lajoie (741754).
Order #002 from Inspection #2022-1580-0002 related to LTCHA, 2007 S.O. 2007, c.8, s. 139 (1) inspected by Rita Lajoie (741754)
Order #003 from Inspection #2022-1580-0002 related to O.Reg. 246/22, s. 79 (1) 9. inspected by Sami Jarour (570)
Order #004 from Inspection #2022-1580-0002 related to O. Reg. 79/10, s. 8 (1) (b) inspected by Sami Jarour (570)
Order #005 from Inspection #2022-1580-0002 related to LTCHA, 2007, s. 24 (1) inspected by Sami Jarour (570)

Order #006 from Inspection #2022-1580-0002 related to LTCHA, 2002, s. 23 (1) (a) inspected by Sami Jarour (570)
Order #007 from Inspection #2022-1580-0002 related to FLTCA, 2021, s. 6 (4) (a) inspected by Sami Jarour (570)
Order #008 from Inspection #2022-1580-0002 related to O.Reg. 246/22, s. 102 (8) inspected by Rita Lajoie (741754)
Order #009 from Inspection #2022-1580-0002 related to O.Reg. 246/22, s. 41 (1) (a) inspected by Sami Jarour (570)

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 267 (2) (a)

The licensee has failed to ensure that the visitor logs included the contact information of the visitor.

During the active screening process, Inspectors # 741754 and #570 were not asked for their contact information.

Inspector #741754 observed visitors providing verbal information to screening staff including name, room number of resident being visited, time of entry/time of exit which was entered into a log. Visitors

completed online screening with a tablet. No contact information was collected in the online screening tool. Visitors did not provide contact information upon entry and when screened. The completed visitor logs did not include visitors contact information.

A screener stated that they did not collect visitors' contact information as there was no direction to collect this information.

The IPAC lead acknowledged that screeners did not collect contact information when screening visitors entering the home. The IPAC lead updated the visitors log to include contact information.

There was minimal risk to the residents when the home did not collect visitor's contact information.

Sources: Inspector's observations; Interviews with Screeners and the IPAC lead; Directive #3, last revised May 3, 2022, COVID-19 guidance document for long-term care homes in Ontario, last revised October 14, 2022. [741754]

Date Remedy Implemented: December 7, 2022

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) (b), Infection Prevention and Control (IPAC) Standard Section 9.1 (d)

The licensee has failed to ensure that any standard issued by the Director with respect to Infection Prevention and Control (IPAC), were complied with.

Rationale and Summary

Inspector #741754 observed three people sitting in a common area within close proximity to each other (less than six feet) with masks down while eating. Residents and visitors were noted in the immediate area.

The IPAC lead confirmed that the three people observed with their masks down are required to eat in the designated staff room.

By not ensuring that the Universal Masking requirements set out in the IPAC Standard were followed there was a potential risk of infection transmission, including the COVID-19 virus.

Sources: Observations; Interview with the IPAC lead [741754]

WRITTEN NOTIFICATION: REPORTING AND COMPLAINTS

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 108 (1) 3. ii. B.

The licensee has failed to ensure that a response was provided to a complainant for a written complaint that included an explanation that the licensee believed the complaint to be unfounded, together with the reasons for the belief.

Rationale and Summary

The home received a written complaint concerning the care of a resident. An investigation was conducted and indicated the allegation was unsubstantiated. Review of the home's investigation notes revealed that a response was not provided to the person who made the complaint that included an explanation that the licensee believed the complaint to be unfounded, together with the reasons for the belief. The Administrator acknowledged that a response should have been sent to the complainant explaining why the home believed the complaint to be unfounded.

The home did not follow their written procedure for dealing with complaints when they failed to provide a response to the complainant. As a result, the complainant was unaware that the home's investigation was concluded, and the complaint believed to be unfounded.

Sources: Interview with Administrator. The home's investigation notes. Policy "Managing and Reporting Complaints" last dated July 2022. [741745]

WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (3) 4.

The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of a resident's fall incident where the resident was transferred to hospital and sustained a significant change in status.

Rationale and Summary

A Critical System Incident (CIS) report was submitted to the Director for an allegation of abuse and a fall of a resident. The CIS report indicated the LTC home received a written complaint indicating that a staff caused a resident from a specified floor to fall. The CIS report indicated a resident on the specified floor was discovered on the floor.

A review of resident's progress notes indicated the resident sustained an unwitnessed fall. The resident was sent to hospital due to complaints of pain. The resident was diagnosed with an injury and was admitted to the hospital.

Nurse Manager (NM) confirmed that the resident had a significant change in status following the fall incident and that a Critical System Incident (CIS) report should have been submitted.

Failing to ensure that the Director was notified of the fall with injury no later than one business day caused no impact to the resident.

Sources: CIS report, progress notes for the resident and interview with NM. [570]

WRITTEN NOTIFICATION: BEHAVIOURS AND ALTERCATIONS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 55 (a)

The licensee has failed to ensure that when a resident exhibited responsive behaviours towards other residents, strategies were developed and implemented to respond to those behaviours to minimize the risk of harm to residents.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director for an incident of alleged abuse. The CIS report indicated that a resident caused a co resident to fall. The co resident sustained an injury.

A review of progress notes for the resident revealed that the resident had exhibited responsive behaviours toward staff and residents on multiple occasions prior to the incident that caused an injury to a co resident.

A review of the plan of care for the resident indicated no interventions were initiated to manage specified responsive behaviours exhibited prior to the incident that caused an injury to a co resident.

Behavioural Support Ontario (BSO)-Registered Practical Nurse (RPN) acknowledged that the resident had exhibited specified responsive behaviours as documented in the progress notes on multiple occasions with no interventions addressing those behaviours until the incident that caused an injury to a co resident.

Failing to ensure that strategies were developed and implemented to respond to resident's responsive behaviours resulted in actual harm to a co resident and put other residents at risk of harm.

Sources: CIS report, progress notes for residents, care plan and interview with BSO/RPN. [570]

WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 123 (3) (a)

The licensee has failed to ensure that the home's medication administration policy related to medication administration documentation was implemented.

Rationale and Summary

During this inspection period, a follow up inspection was completed for Compliance Order (CO) #001 from inspection #2022_1580_0001, FLTCA, 2021 s. 140 (2), CDD Sept 02, 2022. During the inspection, a resident's Medication Administration Records (MAR) were reviewed and revealed that on two instances the medication administration was not documented. RPN Staff verified that the medication was administered but that they had failed to document on the MAR that it was given.

According to the home's Medication Administration Policy staff are required to document on the Medication Administration Record (MAR) immediately after each medication administration by recording the nurse's initials in the appropriate space.

The Director of Care (DOC) and Nurse Manager (NM) both stated that the home's medication administration policy requires that all medications given must be signed off in the resident's MAR, including immediate doses of any medication.

Failing to ensure consistent documentation of medication administration, especially high-risk medications, can put the resident at risk of missing a dose or receiving an inappropriate dose.

Sources: Resident's MAR, Independent Double Check Medication Administration Record and Progress Notes, Medication Administration Policy, Co-sign Medication Administration Record. [741754]

COMPLIANCE ORDER CO #001 PLAN OF CARE

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee must:
1. Review the current plan of care related to falls prevention and toileting for a specified resident with involved PSW staff.
2. Conduct an audit for a two-week period covering all shifts to ensure a specified resident is receiving care related to falls prevention and toileting as directed in the plan of care. Analyze the results of the audits and ensure corrective actions are made.
3. Keep a documented record of all audits completed and any correction actions taken.

Grounds
1. The licensee has failed to ensure that a resident's care related toileting and falls prevention as set out in the plan of care was provided as specified.

A Critical Incident System (CIS) report was submitted to the Director related to an unwitnessed fall for a resident while being toileted. The resident was sent to hospital and diagnosed with an injury.

A review of the home's investigation notes indicated a Personal support Worker (PSW) left the resident unattended for a short period of time while being toileted. The resident sustained unwitnessed fall while being toileted.

A review of the plan of care for the resident indicated the resident was at risk for falls. Staff were to monitor the resident for safety and need for assistance.

Personal Support Worker (PSW) indicated they did not witness the resident when they fell. PSW confirmed the resident was not constantly monitored for safety.

Nurse Manager (NM) indicated that residents with cognitive impairment need to be constantly supervised when toileted and staff should constantly look for cues to assist the resident. The PSW

should have followed the plan of care to monitor the resident as the resident had cognitive impairment and was at risk for falls.

Failure to monitor a resident during toileting had led to a fall that resulted in actual harm to the resident.

Sources: CIS report, progress notes and care plan for resident, interviews with PSW and NM. [570]

2. The licensee has failed to ensure that a resident received assistance in bed mobility and positioning as specified in their plan of care.

A Critical Incident System (CIS) report was submitted to the Director for an incident of alleged staff to resident physical abuse. A resident reported that a PSW staff was rough with them. The resident was assessed and had no injuries and did not complain of pain.

A review of the plan of care for the resident indicated the resident required two staff assistance to reposition and turn in bed.

Personal Support Worker (PSW) indicated that they assisted the resident to reposition in bed by themselves.

Nurse Manager (NM) indicated there were no witnesses to the alleged incident and that the PSW repositioned the resident in bed without the assistance of a second staff. NM indicated the PSW did not follow the resident's plan of care.

Failure to follow the care as directed in the plan of care had put a resident at risk of harm.

Sources: CIS report, progress notes and plan of care for the resident, interview with PSW and NM. [570]

This order must be complied with by March 13, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document
If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to

review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.